(c) FOR EACH INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, MULTIPLY THE PERCENTAGE CALCULATED IN PARAGRAPH (B)(2)(b) OF THIS RULE BY THE FACILITY'S PORTION OF THE COSTS AVAILABLE FOR THE DISTRIBUTION OF FUNDS CALCULATED IN PARAGRAPH (B)(2)(a) OF THIS RULE.

(d) DIVIDE THE PRODUCT IN PARAGRAPH (B)(2)(c) OF THIS RULE BY THE FACILITY'S FISCAL YEAR MEDICAID DAYS TO DETERMINE THE PER DIEM RATE ADJUSTMENT TO BE MADE TO THE INTERIM SETTLEMENT RATE.

(3) FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED MEETING THE CRITERIA ESTABLISHED IN PARAGRAPH (D)(2)(c) OF RULE 5101:3-3-17 OF THE ADMINISTRATIVE CODE THE FOLLOWING APPLIES:

(a) FOR EACH FACILITY WHICH EXPERIENCED A PER DIEM COST GREATER THAN THE PROSPECTIVE PER DIEM RATE DUE TO A REDUCTION IN CERTIFIED BEDS, MULTIPLY THE PER DIEM COST IN EXCESS OF THE PROSPECTIVE RATE BY THE FACILITY'S FISCAL YEAR MEDICAID DAYS TO OBTAIN FOR EACH FACILITY THAT PORTION OF THE COSTS QUALIFYING FOR THE DISTRIBUTION OF FUNDS DESCRIBED IN PARAGRAPH (C) OF RULE 5101:3-3-17 OF THE ADMINISTRATIVE CODE.

(b) DIVIDE THE TOTAL REMAINING FUNDS COLLECTED PURSUANT TO PARAGRAPH (C) OF RULE 5101:3-3-17 OF THE ADMINISTRATIVE CODE BY THE SUM OF THE PRODUCTS CALCULATED IN PARAGRAPH (B)(3)(a) OF THIS RULE TO OBTAIN THE PERCENTAGE OF COSTS EACH INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SHALL BE REIMBURSED. THIS PERCENTAGE SHALL NOT EXCEED ONE HUNDRED PER CENT.

(c) FOR EACH INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, MULTIPLY THE PERCENTAGE CALCULATED IN PARAGRAPH (B)(3)(b) OF THIS RULE BY THE FACILITY'S PORTION OF THE COSTS AVAILABLE FOR THE DISTRIBUTION OF FUNDS CALCULATED IN PARAGRAPH (B)(3)(a) OF THIS RULE.

(d) DIVIDE THE PRODUCT IN PARAGRAPH (B)(3)(c) OF THIS RULE BY THE FACILITY'S FISCAL YEAR MEDICAID DAYS TO DETERMINE THE PER DIEM RATE ADJUSTMENT TO BE MADE TO THE INTERIM SETTLEMENT RATE.

(4) ANY FUNDS REMAINING AFTER PAYMENTS ARE MADE FOR THE PURPOSES DESCRIBED IN PARAGRAPHS (D)(2)(a) TO (D)(2)(c) OF RULE 5101:3-3-17 OF THE ADMINISTRATIVE CODE SHALL BE DISTRIBUTED ACCORDING TO THE FOLLOWING FORMULA:

HCFA-179 # 93-05 Date Rec'd 3-25-93
Supercedes 92-06 Date Appr. JUN 23 1993
State Rep. In [illegible] Date Eff. 10-1-93

TNS # 92-[illegible] APPROVAL DATE 11-1-92
SUPERSEDES
TNS # 91-[illegible] EFFECTIVE DATE 10-1-92

(a) FOR EACH INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, MULTIPLY THE REMAINING EXCESS COST PER DIEM BY THE FACILITY'S FISCAL YEAR MEDICAID DAYS TO OBTAIN THAT PORTION OF EACH FACILITY'S REMAINING EXCESS COST QUALIFYING FOR THE DISTRIBUTION OF FUNDS DESCRIBED IN PARAGRAPH (C) OF RULE 5101:3-3-17 OF THE ADMINISTRATIVE CODE.

(b) DIVIDE THE REMAINING FUNDS COLLECTED PURSUANT TO PARAGRAPH (C) OF RULE 5101:3-3-17 OF THE ADMINISTRATIVE CODE BY THE SUM OF THE PRODUCTS CALCULATED IN PARAGRAPH (B)(4)(a) OF THIS RULE TO OBTAIN THE PERCENTAGE OF REMAINING EXCESS COST EACH INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SHALL BE REIMBURSED. THIS PERCENTAGE SHALL NOT EXCEED ONE HUNDRED PER CENT.

(c) FOR EACH INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, MULTIPLY THE PERCENTAGE CALCULATED IN PARAGRAPH (B)(4)(b) OF THIS RULE BY THE FACILITY'S REMAINING EXCESS COST AVAILABLE FOR THE DISTRIBUTION OF FUNDS CALCULATED IN PARAGRAPH (B)(4)(a) OF THIS RULE.

(d) DIVIDE THE PRODUCT IN PARAGRAPH (B)(4)(c) OF THIS RULE BY THE FACILITY'S FISCAL YEAR MEDICAID DAYS TO DETERMINE THE PER DIEM RATE ADJUSTMENT TO BE MADE TO THE INTERIM SETTLEMENT RATE.

EFFECTIVE DATE: _____

CERTIFICATION: _____

_____
DATE

PROMULGATED UNDER: RC CHAPTER 119.

STATUTORY AUTHORITY: RC SECTION 5111.02, SECTION 23 OF AM. SUB. H. B. 298

RULE AMPLIFIES: RC SECTIONS 5111.01, 5111.02, SECTION 23 OF AM. SUB. H. B. 298

HCFA-179 # 93-05 Date Rec'd 3-25-93
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State Rep. In JH Date Eff. 10-1-93

~~TNS # 92-06 APPROVAL DATE 11-6-92~~
~~SUPERSEDED~~
~~TNS # 92-[illegible] EFFECTIVE DATE 10-1-92~~

5101:3-3-18 AGGREGATE MEDICAID RATES AND AGGREGATE MEDICARE RATES COMPARISON FOR NURSING FACILITIES (NFS) AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFS-MR).

PROSPECTIVE PER DIEM RATES CALCULATED UNDER RULES 5101:3-3-43 AND 5101:3-3-78 OF THE ADMINISTRATIVE CODE FOR NFS AND ICFS-MR WHICH PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM SHALL NOT EXCEED, IN THE AGGREGATE BY FACILITY TYPE, THE AMOUNT THAT CAN REASONABLY BE ESTIMATED TO HAVE BEEN PAID UNDER MEDICARE PAYMENT PRINCIPLES.

REPLACES RULE 5101:3-3-18

EFFECTIVE DATE: _____

CERTIFICATION: _____

_____
DATE

PROMULGATED UNDER: RC CHAPTER 119.

STATUTORY AUTHORITY: RC SECTION 5111.02

RULE AMPLIFIES: RC SECTIONS 5111.01, 5111.02

PRIOR EFFECTIVE DATES: 12/30/77, 12/28/78, 7/3/80, 1/1/84, 10/15/87 (EMER.), 12/31/87, 10/1/91 (EMER.), 12/20/91, 9/30/93 (EMER.)

TNS # 94-07 APPROVAL DATE 6-28-94
SUPERSEDES
TNS # 93-024 EFFECTIVE DATE 10/1/94

5101:3-3-19 RELATIONSHIP OF OTHER COVERED MEDICAID SERVICES TO NURSING FACILITIES (NFS) AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFS-MR) SERVICES.

THIS RULE IDENTIFIES COVERED SERVICES GENERALLY AVAILABLE TO MEDICAID RECIPIENTS AND DESCRIBES THE RELATIONSHIP OF SUCH SERVICES TO THOSE PROVIDED BY A NF OR AN ICF-MR. WHENEVER REFERENCE IS MADE TO REIMBURSEMENT OF SERVICES THROUGH THE "FACILITY COST REPORT MECHANISM," THE PROVISIONS GOVERNING SUCH REIMBURSEMENT AS SET FORTH IN CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE ARE APPLICABLE. FOR STATE-OPERATED ICFS-MR REIMBURSEMENT IS MADE IN ACCORDANCE WITH RULE 5101:3-3-99 OF THE ADMINISTRATIVE CODE. ALL REFERENCES TO "ICFS-MR" SET FORTH IN PARAGRAPHS (A) TO (K) OF THIS RULE DO NOT INCLUDE STATE-OPERATED ICFS-MR.

(A) DENTAL SERVICES.

ALL COVERED DENTAL SERVICES PROVIDED BY LICENSED DENTISTS ARE REIMBURSED DIRECTLY TO THE PROVIDER OF THE DENTAL SERVICES IN ACCORDANCE WITH CHAPTER 5101:3-5 OF THE ADMINISTRATIVE CODE. PERSONAL HYGIENE SERVICES PROVIDED BY FACILITY STAFF OR CONTRACTED PERSONNEL ARE REIMBURSED THROUGH THE FACILITY COST REPORT MECHANISM.

(B) LABORATORY AND X-RAY SERVICES.

COSTS INCURRED FOR THE PURCHASE AND ADMINISTRATION OF TUBERCULIN TESTS, AND FOR DRAWING SPECIMENS AND FORWARDING SPECIMENS TO A LABORATORY, ARE REIMBURSABLE THROUGH THE FACILITY'S COST REPORT. ALL LABORATORY AND X-RAY PROCEDURES COVERED UNDER THE MEDICAID PROGRAM ARE REIMBURSED DIRECTLY TO THE LABORATORY OR X-RAY PROVIDER IN ACCORDANCE WITH CHAPTER 5101:3-11 OF THE ADMINISTRATIVE CODE.

(C) MEDICAL SUPPLIER SERVICES.

CERTAIN MEDICAL SUPPLIER SERVICES ARE REIMBURSABLE THROUGH THE FACILITY'S COST REPORT MECHANISM AND OTHERS DIRECTLY TO THE MEDICAL SUPPLY PROVIDER AS FOLLOWS:

(1) ITEMS WHICH MUST BE REIMBURSED THROUGH THE FACILITY'S COST REPORT INCLUDE:

(a) COSTS INCURRED FOR "NEEDED MEDICAL AND PROGRAM SUPPLIES" DEFINED AS THOSE ITEMS WHICH HAVE A VERY LIMITED LIFE EXPECTANCY SUCH AS ATOMIZERS, NEBULIZERS, BED PANS, CATHETERS, ELECTRIC PADS, HYPODERMIC NEEDLES, SYRINGES, INCONTINENCE PADS, SPLINTS, AND DISPOSABLE VENTILATOR CIRCUITS.

(b) COSTS INCURRED FOR "NEEDED MEDICAL EQUIPMENT" (AND REPAIR OF SUCH EQUIPMENT), DEFINED AS ITEMS WHICH CAN STAND REPEATED USE, ARE PRIMARILY AND CUSTOMARILY USED TO SERVE A MEDICAL PURPOSE, ARE NOT USEFUL TO A PERSON IN THE ABSENCE OF ILLNESS OR INJURY, AND ARE APPROPRIATE FOR THE USE IN THE FACILITY. SUCH MEDICAL EQUIPMENT ITEMS INCLUDE HOSPITAL BEDS, WHEELCHAIRS, AND INTERMITTENT POSITIVE-PRESSURE BREATHING MACHINES, EXCEPT AS NOTED IN PARAGRAPH (C)(2) OF THIS RULE.

(c) COSTS OF EQUIPMENT ASSOCIATED WITH OXYGEN ADMINISTRATION, SUCH AS CARTS, REGULATORS/HUMIDIFIERS, CANNULAS, MASKS, AND DEMURRAGE.

(2) SERVICES WHICH ARE REIMBURSED DIRECTLY TO THE MEDICAL SUPPLIER PROVIDER, IN ACCORDANCE WITH CHAPTER 5101:3-10 OF THE ADMINISTRATIVE CODE, INCLUDE:

(a) CERTAIN DURABLE MEDICAL EQUIPMENT ITEMS, SPECIFICALLY, VENTILATORS, AND CUSTOM-MADE WHEELCHAIRS WHICH HAVE PARTS WHICH ARE ACTUALLY MOLDED TO FIT THE RECIPIENT.

(b) "PROSTHESES," DEFINED AS DEVICES WHICH REPLACE ALL OR PART OF A BODY ORGAN TO PREVENT OR CORRECT PHYSICAL DEFORMITY OR MALFUNCTION, SUCH AS ARTIFICIAL ARMS OR LEGS, ELECTRO-LARYNXES, AND BREAST PROSTHESES.

(c) "ORTHOSES," DEFINED AS DEVICES WHICH ASSIST IN CORRECTING OR STRENGTHENING A DISTORTED PART, SUCH AS ARM BRACES, HEARING AIDS AND BATTERIES, ABDOMINAL BINDERS, AND CORSETS.

(d) CONTENTS OF OXYGEN CYLINDERS OR TANKS, INCLUDING LIQUID OXYGEN, EXCEPT THAT EMERGENCY STAND-BY OXYGEN IS REIMBURSED THROUGH THE FACILITY COST REPORT MECHANISM.

(e) OXYGEN PRODUCING MACHINES (CONCENTRATORS) FOR SPECIFIC USE BY AN INDIVIDUAL RECIPIENT.

(D) PHARMACEUTICALS.

(1) OVER-THE-COUNTER DRUGS NOT LISTED IN THE "OHIO MEDICAID DRUG FORMULARY," DRUGS FOR WHICH PRIOR AUTHORIZATION WAS REQUESTED AND DENIED, AND NUTRITIONAL SUPPLEMENTS ARE REIMBURSABLE ONLY THROUGH THE FACILITY COST-REPORT MECHANISM.

(2) ALL OTHER PHARMACEUTICALS WHICH EITHER ARE LISTED IN THE "OHIO MEDICAID DRUG FORMULARY, OR FOR WHICH PRIOR AUTHORIZATION WAS REQUESTED AND APPROVED, ARE REIMBURSABLE DIRECTLY TO THE PHARMACY PROVIDER FOR RESIDENTS OF NFS AND ICFS-MR. SERVICES REIMBURSABLE DIRECTLY TO THE PHARMACY PROVIDER ARE SUBJECT TO THE FOLLOWING CONDITIONS:

(a) DRUG AMOUNTS MUST BE DISPENSED NOT TO EXCEED MAXIMUM PRESCRIPTIONS QUANTITIES ESTABLISHED BY THE OHIO DEPARTMENT OF HUMAN SERVICES (ODHS).

(b) REFILL DATES MUST BE MAINTAINED WITH THE ORIGINAL PRESCRIPTION RECORD. REFILLS ARE LIMITED TO ELEVEN TIMES OR ONE YEAR, WHICHEVER COMES FIRST; FOR NONSCHEDULED DRUGS; FIVE TIMES OR SIX MONTHS, WHICHEVER COMES FIRST, FOR SCHEDULE III, IV, AND V DRUGS; AND NONE FOR SCHEDULE II DRUGS.

(c) FOR CHRONIC MAINTENANCE MEDICATIONS, THE PHARMACY PROVIDER MAY ONLY BILL FOR ONE DISPENSING FEE PER MEDICATION PER MONTH.

(d) WHEN NEW PRESCRIPTIONS ARE NECESSARY FOLLOWING EXPIRATION OF THE LAST REFILL, THE NEW PRESCRIPTION MAY BE ORDERED ONLY AFTER THE PHYSICIAN EXAMINES THE PATIENT.

(e) A COPY OF ALL RECORDS REGARDING PRESCRIBED DRUGS FOR ALL PATIENTS MUST BE RETAINED BY THE DISPENSING PHARMACY FOR AT LEAST SIX YEARS. A RECEIPT FOR DRUGS DELIVERED TO A NF OR AN ICF-MR MUST BE SIGNED BY THE FACILITY REPRESENTATIVE AT THE TIME OF DELIVERY AND A COPY RETAINED BY PHARMACY.

(E) PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AND AUDIOLOGY SERVICES.

(1) FOR NFS, THE COSTS INCURRED FOR COVERED THERAPY SERVICES PROVIDED BY LICENSED PRACTITIONERS ARE REIMBURSED DIRECTLY TO THE NF AS SPECIFIED IN RULES 5101:3-3-47 TO 5101:3-3-473 OF THE ADMINISTRATIVE CODE. THE COSTS INCURRED FOR THESE SERVICES PROVIDED BY NURSING STAFF OF THE NF ARE REIMBURSABLE THROUGH THE FACILITY COST REPORT MECHANISM AS SPECIFIED IN RULE 5101:3-3-46 OF THE ADMINISTRATIVE CODE.

(2) FOR ICFS-MR, THE COSTS INCURRED FOR THESE SERVICES ARE REIMBURSABLE THROUGH THE FACILITY COST REPORT MECHANISM IN ACCORDANCE WITH RULE 5101:3-3-80 OF THE ADMINISTRATIVE CODE.

(F) PHYSICIAN SERVICES.

(1) A PHYSICIAN MAY BE DIRECTLY REIMBURSED FOR THE FOLLOWING SERVICES PROVIDED BY A PHYSICIAN TO A RESIDENT OF A NF OR ICF-MR:

(a) ALL COVERED DIAGNOSTIC AND TREATMENT SERVICES IN ACCORDANCE WITH CHAPTER 5101:3-4 OF THE ADMINISTRATIVE CODE.

(b) ALL MEDICALLY NECESSARY PHYSICIAN VISITS IN ACCORDANCE WITH RULE 5101:3-4-06 OF THE ADMINISTRATIVE CODE.

(c) ALL REQUIRED PHYSICIAN VISITS AS DESCRIBED BELOW WHEN THE SERVICES ARE BILLED IN ACCORDANCE WITH RULE 5101:3-4-06 OF THE ADMINISTRATIVE CODE.

(i) PHYSICIAN VISITS MUST BE PROVIDED TO A RESIDENT OF A NF OR ICF-MR AND MUST CONFORM TO THE FOLLOWING SCHEDULE:

(a) FOR NURSING FACILITIES, THE RESIDENT MUST BE SEEN BY A PHYSICIAN AT LEAST ONCE EVERY THIRTY DAYS FOR THE FIRST NINETY DAYS AFTER ADMISSION, AND AT LEAST ONCE EVERY NINETY DAYS, THEREAFTER.

(b) A PHYSICIAN VISIT IS CONSIDERED TIMELY IF IT OCCURS NOT LATER THAN TEN DAYS AFTER THE DATE THE VISIT WAS REQUIRED.

(ii) FOR REIMBURSEMENT OF THE REQUIRED PHYSICIAN VISITS, THE PHYSICIAN MUST:

(a) REVIEW THE RESIDENT'S TOTAL PROGRAM OF CARE INCLUDING MEDICATIONS AND TREATMENTS, AT EACH VISIT REQUIRED BY PARAGRAPH (F)(1)(c)(i) OF THIS RULE;

(b) WRITE, SIGN, AND DATE PROGRESS NOTES AT EACH VISIT;

(c) SIGN ALL ORDERS; AND

(d) PERSONALLY VISIT (SEE) THE PATIENT EXCEPT AS PROVIDED IN PARAGRAPH (F)(1)(c)(iii) OF THIS RULE.

(iii) AT THE OPTION OF THE PHYSICIAN, REQUIRED VISITS AFTER THE INITIAL VISIT MAY BE DELEGATED IN ACCORDANCE WITH PARAGRAPH (F)(1)(c)(iv) OF THIS RULE AND ALTERNATE BETWEEN PHYSICIAN AND VISITS BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER.

(iv) PHYSICIAN DELEGATION OF TASKS.

(a) A PHYSICIAN MAY DELEGATE TASKS TO A PHYSICIAN ASSISTANT OR NURSE PRACTITIONER WHO:

(i) MEETS THE APPLICABLE DEFINITION OF SECTION 491.2 OF THE CODE OF FEDERAL REGULATIONS (CFR);

(ii) IS ACTING WITHIN THE SCOPE OF PRACTICE AS DEFINED BY STATE LAW;

(iii) IS UNDER SUPERVISION AND EMPLOYMENT OF THE BILLING PHYSICIAN.

(b) A PHYSICIAN MAY NOT DELEGATE A TASK WHEN REGULATIONS SPECIFY THAT THE PHYSICIAN MUST PERFORM IT PERSONALLY, OR WHEN DELEGATION IS PROHIBITED BY STATE LAW OR THE FACILITY'S OWN POLICIES.

(2) SERVICES DIRECTLY REIMBURSABLE TO THE PHYSICIAN MUST:

(a) BE BASED ON MEDICAL NECESSITY AND REQUESTED BY THE NF OR ICF-MR RESIDENT WITH THE EXCEPTION OF THE REQUIRED VISITS DEFINED IN PARAGRAPH (F)(1)(c) OF THIS RULE; AND

(J) VISION CARE SERVICES.

ALL COVERED VISION CARE SERVICES, INCLUDING EXAMINATIONS, DISPENSING, AND THE FITTING OF EYEGLASSES, ARE REIMBURSED DIRECTLY TO AUTHORIZED VISION CARE PROVIDERS IN ACCORDANCE WITH CHAPTER 5101:3-6 OF THE ADMINISTRATIVE CODE.

(K) PODIATRY SERVICES.

COVERED SERVICES PROVIDED BY LICENSED PODIATRISTS ARE REIMBURSED DIRECTLY TO THE AUTHORIZED PODIATRIC PROVIDER IN ACCORDANCE WITH CHAPTER 5101:3-7 OF THE ADMINISTRATIVE CODE. PAYMENT BY ODHS IS LIMITED TO ONE VISIT PER MONTH FOR RESIDENTS IN A NF OR ICF-MR SETTING.

REPLACES RULE 5101:3-3-11

EFFECTIVE DATE: _____

CERTIFICATION: _____

_____
DATE

PROMULGATED UNDER: CHAPTER 119.

STATUTORY AUTHORITY: RC SECTION 5111.02

RULE AMPLIFIES: RC SECTIONS 5111.01, 5111.02, 5111.20

PRIOR EFFECTIVE DATES: 7/1/80, 3/1/84, 9/1/89, 10/1/90 (EMER.), 12/31/90

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